PATIENT INFORMATION

PATIENT NAME: ____________________ ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female

SOCIAL SECURITY # ____________________ **BIRTH DATE**: Month: __________ Day: ____ Year: ______

ADDRESS: Street ____________________ Apartment/Unit _____ City: __________ State: ____ Zip: ______

TELEPHONE: Home: __________ Work: __________ Cell: __________ **E-MAIL**: __________

NAME OF EMPLOYER: ____________________ **ADDRESS:** ____________________

IF FULL TIME STUDENT, SCHOOL NAME: ____________________ **GRADE:** ______

PERSONAL RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE: ☐ Patient ☐ Guardian ☐ Spouse ☐ Father ☐ Mother

INSURANCE INFORMATION

***Note:** Minor child may need to complete both blocks for parent information; Adults – Complete Primary Insured; Dual Coverage? Also complete secondary insured.*

PRIMARY INSURED __________	**SECONDARY INSURED** __________
Street __________	Street __________
City: __________ State: ____ Zip: ______	City: __________ State: ____ Zip: ______
Home: ______ Work: ______ Cell: ______	Home: ______ Work: ______ Cell: ______
E-MAIL: __________ DOB: ______	E-MAIL: __________ DOB: ______
Relationship to Patient: ______ SS#: ______	Relationship to Patient: ______ SS#: ______
Employer: __________	Employer: __________
Dental Insurance Company: __________	Dental Insurance Company: __________
Subscriber #: ______ Group #: ______	Subscriber #: ______ Group #: ______

PERSON TO CONTACT IN CARE OF EMERGENCY:

NAME: ____________________

ADDRESS: Street ____________________ City: __________ State: ____ Zip: ______

TELEPHONE: Home: __________ Work: __________ Cell: __________

Has any member of your family every been treated in our office? ☐ Yes ☐ No Whom may we thank for referring you?__________

METHOD OF PAYMENT:

Responsible party currently has an account with this office? ☐ Yes ☐ No

☐ Payment in full at each appointment (cash of personal check) ☐ Payment in full at each appointment (☐ VISA ☐ MC ☐ OTHER)

☐ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE: *(Terms to be completed by office personnel)* If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____ % per month (or a minimum charge of $__________ for a balance under ________) which is an annual percentage rate of ________% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X ____________________ **Date**: __________ **State Driver's License #:** __________

Signature of Patient or Responsible Party